NH MEDICAL CONTROL BOARD

Richard M. Flynn Fire Academy
222 Sheep Davis Road
Concord, NH

MINUTES OF MEETING

March 16, 2006

Members Present: Tom D'Aprix, MD, Frank Hubbell, DO; Jim Martin, MD; Joseph Mastromarino, MD; Douglas McVicar, MD; Sue Prentiss, Bureau Chief; William Siegart, DO;

Members Absent: Donavon Albertson, MD; Chris Fore, MD; Jeff Johnson, MD; Patrick Lanzetta, MD; Joseph Sabato, MD; John Sutton, MD; Norman Yanofsky, MD

Guests: Dave Dubey, Jonathan Dubey, Janet Houston, Jeanne Erickson, Steve Erickson, Jeff Stone, Pamela Drewniak, Paul Luizzi, William Thorpe, Jr., Mary Reed, Michael Pepin, Doug Martin, David Hogan, Brad D. Weilbrenner, Liz Karagosian, MD, Harry C. Brown, Phyllis Manning

Bureau Staff: Vicki Blanchard, ALS Coordinator, Liza Burrill, Kathy Doolan, Field Services Coordinator; Clay Odell, Trauma Coordinator; Fred von Recklinghausen, Research Coordinator

I. CALL TO ORDER

Item 1. McVicar called the meeting of the NH Medical Control Board (MCB) to order by on March 16, 2006 at the Richard M. Flynn Fire Academy in Concord, NH. 09:00 AM.

Introductions were conducted.

II. ACCEPTANCE OF MINUTES

Item 1. January 19, 2006 Minutes were previously approved via the email/electronic procedure established in March 2005.

III. DISCUSSION AND ACTION PROJECTS

Item 1. Protocol Transition Program: Blanchard presented an overview of the 2006 Protocol Transition Program. This is a training program developed to address the skills necessary to carryout standing orders in the NH Patient Care Protocols that are not covered under the Department of Transportation Curriculum for Emergency Medical Technicians. The program includes

objectives, preparatory information, instructor outline, skill sheets, rosters, written examinations and power point presentations. The topics covered are as follows:

EMT-Basic (to include NREMT-Basics and NH EMT-Basics)

- Advanced Spinal Assessment
- Anaphylaxis
- Aspirin Administration
- Blind Airways (Combi-tube & KING LT-D)
- Blood Glucose Monitoring
- Cyanide Kit Administration
- ECG Placement
- Mark 1 Kit Administration
- Tracheostomy Maintenance

EMT-Intermediate:

- All of those skills taught to the EMT-Basic plus:
- Intermediate Pharmacology (to replace the "Meds. Modules)
- Intermediate Cardiology (to replace the "Manual Defibrillation Module)
- Laryngeal Mask Airway (LMA)

EMT-Paramedic:

- Advanced Spinal Assessment
- Blind Airway Adjuncts
- Blood Glucose Monitoring
- CPAP
- Cricothyrotomy (under MD supervision)
- Cyanide Kit Administration
- Laryngeal Mask Airway
- Mark 1 Kit (Nerve Agent)

Item 2: Prehospital Heparin: Mastromarino proposed to the Board a pilot heparin program for the Exeter Hospital. Prior to the meeting Mastromarino provided to all members for review an article from the *Journal of the American College of Cardiology* titled, "Influence of prehospital administration of aspirin and heparin on initial patency of the infarct-related artery in patients with acute ST elevation myocardial infarction," by Zijlstra, et al.

Mastromarino pointed out the results and conclusions of the article -- "Prehospital administration of aspirin and heparin results in a higher initial patency of the infarct-related artery in patients with acute MI." A sample protocol was handed out to the board for review. Mastromarino felt that with a selected group of paramedics additionally trained in 12 Lead EKG interpretation and prehospital aspirin and heparin administration, working closely with the emergency department and cath lab team, after a review period, would be able to show the board results demonstrating improved patient outcome.

Detailed discussion followed. D'Aprix cited a number of specific weaknesses of the Zijlstra study. Further critique of the Zijlstra paper provided by Yanofsky and Albertson by email was read to the board. Some of the specific issues raised were: The absence of randomization, the lack of difference in mortality between the pre-hospital heparin group and the non-pre-hospital heparin group, a

question about whether the Netherlands uses physicians on their ambulances, and the role of IV aspirin. Yanofsky commented that the IV aspirin might be a more important innovation and have had more influence on the improved outcome than the heparin.

Mastromarino replied that IV aspirin was not, as far as he knew, available here, so its use was moot. Also PO aspirin is so rapidly effective that IV administration may offer no advantage.

Siegart agreed the study was not perfect but stated that it was well known that the sooner aspirin is given the better. EMS then extended that knowledge into the prehospital setting. By analogy, since we also know the earlier heparin is given the better, shouldn't that go into the prehospital setting as well? Since Exeter Hospitals has an aggressive cardiac center and excellent cooperation with the emergency department and paramedics, Exeter would be an ideal setting in which to extend this care prehospitally with a pilot program.

McVicar commented that he felt the board's authority in years past to institute "pilot programs" was probably eliminated by HB 257 and the coming of statewide protocol under rule. McVicar felt that the research value of "pilot programs" or "research protocols" so-called, had always been minimal anyway.

Several members expressed concern that if this was to be a research project, then Institutional Review Board approval would be required. Mastromarino stated that no such approval had been requested.

Prentiss stated that the correct terminology should be "evaluative study" and not "pilot program." She shares the concern that these evaluative studies may no longer be legal under protocol, and stated she would speak to legal council to find the answer to the legal side of the situation.

D'Aprix moved, "that we not approve the program at this time and ask Mastromarino to come back with additional information." Discussion of the motion led to some specific examples of information that would be useful in evaluating the Zijlstra study, or more directly, answering the question of whether a pre-hospital heparin protocol would be useful for NH EMS.

For example:

1. Aspirin and heparin versus aspirin alone
2. IV aspirin versus PO aspirin
3. Heparin earlier, what is the advantage? Are there risks?
4. Unfractionated versus low molecular weight heparin.

Martin 2nd. Motion accepted.

Mastromarino stated he would consult with Exeter cardiology and bring more information to the next meeting.

A break was taken at this time. Following the break, McVicar invited Dr. Liz Karagosian from Southern New Hampshire Medical Center to the table. Karagosian was welcomed by all.

Item 3: External Jugular Cannulation for EMT-Intermediates. Blanchard requested from the board a position regarding external jugular cannulation (EJ-IV) for EMT-Intermediates. Blanchard explained that prior to Statewide Protocol, there were intermediates throughout the state that were taught EJ-IV's. Recently Blanchard received a telephone call from an instructor who wanted clarification as she wanted to teach the skill to her intermediate students but could not find any reference to the skill in the protocols.

Von Recklinghausen reported that the TEMSIS database contains 46 cases in which EJ-IV was performed – all 46 by paramedics, most in extremely ill patients.

Both Albertson and Yanofsky, sent a statement to McVicar regarding this topic. Albertson stated that he was not against intermediates starting EJ-IV's. Yanofsky stated he felt it was "pushing the limits."

Prentiss stated that she was aware of some intermediates being taught under medical direction EJ-IV's and she felt they were competent in the skill.

Jeanne Erickson stated there were six intermediates in her area who had been taught to perform EJ-IV's. She is concerned that if EMT-I's aren't allowed to perform EJ-IV then they need another route -- perhaps intraosseus (IO) -- for difficult sticks in patients who are in extremis.

Bud Thorpe stated he was not teaching EJ-IV's. He felt it added more to an already lengthy program. Instead more time and energy should be spent learning core skills, like regular IV skills.

Doolan stated that she was aware that the ALS Institute did teach EJ-IV skills to intermediate students.

Hubbell moved, "External Jugular cannulation be limited to a paramedic skill, and to instruct the protocol subcommittee to research and report back on the consideration of intermediates using alternative IV sites such as IO access or other peripheral sites." Mastromarino 2nd. Unanimously approved.

Item 4: 2007 Protocol progress report: Martin reported for the protocol subcommittee the following:

Flowcharts: flowchart samples were developed and handed out to the committee for review. Hubbell commented that flowcharts had fallen to the wayside in education since, while they are useful for some, they proved to be a difficult tool for many.

Graphic Design: The committee recommended that Blanchard investigate the process needed to acquire a "graphic designer" to make a more reader-friendly version of the document. Hubbell volunteered the staff of his publishing

company to look at the project and give feed back. The board agreed that Blanchard should send ten to twenty sample pages to Hubbell for development.

Protocol Development: Houston had submitted a protocol "Apparent Life Threatening Events" for children who were reported to be apneic in the out-of-hospital setting, yet appeared stable by the time EMS arrived. The committee agreed this would be better addressed by enhancing the Routine Patient Care Guidelines, rather than creating a separate protocol. The committee considered a protocol for accessing subcutaneous implanted ports (e.g. Port-A-Cath®, Infus-A-Port®, Mediport®) and peripherally inserted central venous catheters ("PICC lines"). The subcommittee felt access to a PICC line should be considered. It was the recommendation of the protocol subcommittee that subcutaneous implanted ports not be accessed by EMS; but if an existing patent IV was already in place via a subcutaneous implanted ports upon arrival of EMS, it could be used.

Protocol Development: In regards to the "vagus nerve stimulator" the seizure protocol will add the statement, "consider the presence of a vagus nerve stimulator," however there would be no change in patient care.

Ventilator protocol to be reviewed and incorporated into the Tracheostomy Maintenance transition program and then further reviewed for protocol update.

Jeff Stone asked for clarification regarding the Interfacility Transfer Protocol. He stated that some providers felt that the Interfacility Transfer protocols would cover pre-hospital use of a non-approved medication in an emergency situation. Stone indicated that he felt uncomfortable with this legal basis for going outside the approved drug list. However in a case such as a child with a bleeding disorder who needs a factor concentrate ASAP, he feels EMS should have a way to provide service.

McVicar agreed that in the example given, it would not be legal to administer the medication under the Interfacility Transfer (IFT) Protocol. The intent of the IFT protocol is that the patient be assessed by a physician who would order the medication and dosing schedule, and that the medication would be started prior to transport.

Dave Dubey spoke to emphasize a cooperative, individualized program for special needs patients under generic guidelines, and recommended a generic release form be developed that would allow EMS providers to implement special needs procedures after receiving specialized training in the specific procedure.

Janet Houston spoke of SKIP (Special Kids Information Program), through which children with special healthcare needs were served by cooperation and special training and planning involving the parents, the patient's physician or nurse specialist, and local EMS. Board members expressed their feeling that this sort of process would be more practical than development of a long list of special protocols addressing particular needs of small numbers of patients, and should be encouraged both for adult as well as pediatric patients.

However, in urban areas, especially those with large institutions like the state prison, and in high-volume vacation areas there would be a problem tracking a large number of such patients and their changing needs.

Another approach is to utilize on-line medical control. Mastromarino indicated that it would be impossible to create language that covers every situation. He felt that some of these situations could involve lifesaving actions, so it can be better to seek forgiveness rather than to get permission.

The MCB agreed to try to get some clearer guidance to the providers. The consensus at the end of the discussion was that within the limits created by law, we want to create flexibility to address needs that go beyond protocol.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: Prentiss reported that Sabato has been in contact with Dr. Peter Moyer, a physician associated with Boston EMS, regarding prehospital thrombolytics. Since there was quite a bit of interest in the topic at the Medical Control Roundtable in January, Sabato is working on getting Dr. Moyer here for further discussion.

Bureau and Division Update: Prentiss presented her Bureau report. (see attached). Further Prentiss stated that there appeared to be an issue with ambulances traveling through the tollbooths without EZ Pass transponders. Some have gotten tickets. It is being reviewed and a solution is being worked out.

Intersections Project: : No report.

New Hampshire Respiratory Care Practitioners Governing Board. McVicar reported that there was an NH emergency department with a shortage of respiratory care, which looked at the paramedic skill set and found many skills which could be highly useful in a respiratory therapy department. They hired a medic for full time work in the respiratory department, in a limited roll. A complaint was made to the Respiratory Care Practitioners Board and that board felt the medic was performing beyond a paramedic's scope of practice.

Unfortunately, before EMS was consulted the Respiratory board sent a letter to all NH hospitals. This letter has been a source of confusion and concern. In an effort to alleviate these concerns, EMS has been meeting and opening paths of communication. We met with the hospital involved, and with the Respiratory board. One important principle that all will try to observe, is that each agency is responsible, under its own statute and rules, for its own licensed practitioners. In the modern world of health care there are, of course, areas of overlap, or even of conflict. In those cases, good interdisciplinary communication is indicated.

With the help of legal counsel, Prentiss is drafting a letter to all NH hospitals clarifying the law on EMS. With the spirit of the important principle of communication in mind, we will send a courtesy copy of the letter to the Board of Respiratory Care Practitioners Governing Board for their approval before we send it out.

NH Trauma System: No report.

TEMSIS: von Recklinghausen reported the following

- It was the third anniversary of the first TEMSIS meeting.
- Compliance: services have been identified who have not had TEMSIS training and are being addressed.
- The average entry time is now 18.9 minutes.
- He is working with other software venders to ensure compatibility for those using other systems
- The "frequent flyer" feature is being further developed and will soon be available. It should save significantly on key punch time.
- Different reports are being looked at, in response to requests from the field.
- The TEMSIS Committee is evolving, and becoming more of a users group. Five special interest sections will address: scoring, initial & ongoing education, data dictionary, templates and process.

Other Business: The question of extended First Responder skill set was put into the hands of the Coordinating Board, who set up a committee to address the issue. Liza Burrill gave an overview of the committee's recommendations. She will be presenting the committee's recommendation this afternoon to the Coordinating Board for official approval.

Doolan reported that the EMS Week Planning Guides have arrived and will be sent out next week to licensed units.

V. ADJOURNMENT

Motion by Hubbell, seconded by Siegart to adjourn. Approved. Meeting adjourned at 12:00.

VI. NEXT MEETING

May 18, 2006 at the Richard M. Flynn Fire Academy in Concord, New Hampshire.

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)